MEDICAL HISTORY FORM

(COMPLETION OF THIS SIDE OF THE FORM IS OPTIONAL)

Name:_____ Date:_____

Address:_____ Birth date:_____

_____

Daytime Phone:_____ Evening Phone:_____

WHO TO CONTACT IN CASE OF AN EMERGENCY?

Name:_____ Relationship:_____

Daytime Phone:_____ Evening Phone:_____

Physician's Name:_____

Daytime Phone:_____ Evening Phone:_____

Hospital of Choice:_____

PLEASE COMPLETE THE FOIIOWING:

If the answer to any of the following questions is or was yes, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

Have you had (or do you presently have) any of the following?	**Circle One**	
Head injury (concussion, skull fracture)	Yes	No
Fainting spells	Yes	No
Convulsions/epilepsy	Yes	No
Neck or back injury	Yes	No
Asthma	Yes	No
High blood pressure	Yes	No
Kidney problems	Yes	No
Hernia	Yes	No
Diabetes	Yes	No
Heart murmur	Yes	No
Allergies	Yes	No
Please specify:_____		
Injuries to:		
Shoulder	Yes	No
Knee	Yes	No
Ankle	Yes	No
Fingers	Yes	No
Arm	Yes	No
Other: :_____		
Impaired vision	Yes	No
Impaired hearing	Yes	No
Other: :_____		

Have you had a recent tetanus booster? _____ If so, when? _____

Are you currently taking any medications?_____ What?Why?_____

_____

Has the doctor placed any restrictions on your activity?_____ Explain:_____

_____